

Dental Discount Plan

Little Rockies Pediatric Dentistry

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Parker, CO 80138

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Discount Dental Plan

This is a discount dental plan that allows individuals without insurance to receive dental care at our practice for a discounted price. This is an annual plan for individuals and/or families.

This plan includes preventative and diagnostic care twice a year at no charge. Other procedures will be offered at a reasonable price.

ELIGIBILITY: Families, dependents under the age of 25 and dependents with special needs.

ENROLMENT: Enrollment can take place at any time. This is an annual plan that can be paid in full or monthly. Enrolment fees will be billed at time of enrollment.

1 Member \$120 yearly or \$12 per month

1 Member and 1 Dependent \$210 or \$20 per month

1 Member and 2 Dependents \$300 or \$27 per month

1 Member and 3 Dependents \$390 or \$35 per month

1 Members and 4 or more Dependents \$480 or \$42 month

PLAN BENEFITS: This discount plan includes the following at no charge: 2 cleanings, comprehensive exam, radiographs, cancer screening, periodontal examination, and other preventive services per calendar year. Each office visit will require a co-payment of \$20.00. All other procedures will be billed according to the attached fee plan.

PAYMENTS: All co-payments, and procedure fees will be due at the time of service. Monthly discount payments will be billed out on the 5st of every month.

Member Registration Form

Dental Insurance Discount Plan

First Name	Middle	Last Name
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Home Address	Apt #
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City	State	Zip
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Home Phone	Cell Phone	Work Phone
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Date of Birth	Employer Name
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Email Address

Dependents	Date of Birth	Relationship
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Dependents	Date of Birth	Relationship
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Dependents	Date of Birth	Relationship
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Dependents	Date of Birth	Relationship
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Dependents	Date of Birth	Relationship
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Dependents	Date of Birth	Relationship
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Payment Options Discount Dental Plan

Select Payment Method

Circle One: ANNUAL

MONTHLY

Charge Card

Name on Card _____

Card Number _____

Expiration Date _____

Security Code _____

I understand the benefits, limitations, exclusions and requirements of the Plan and I agree to the following: I will remain in the plan and pay membership fees for a minimum of 12 months. Payment of less than 12 months' membership fees may result in my being charge usual and customary fees for all services (including those already provided) and my being charged remaining months' fees in lump sum. Fees for dental services are due at the time of services being rendered. Fees for prosthodontic and cast restoration services are due at the preparation/impression visit. Failure to comply may result in my being charged usual and customary fees for such services. I agree to pay and all costs in collecting all charges, including but not limited to attorney fees and court costs. Coverage must be continuous. Missing monthly payments must be made up for interrupted coverage. Last month and processing fees are not refundable.

Membership Enrollment Type (Please circle one)

1 Member

1 Member 1 Dependent

1 Member 2 Dependents

1 Member 3 Dependents

1 Member 4 +Dependents

Signature (Required) _____

TERMS AND CONDITIONS OF AUTHORIZATION TO HONOR DEBITS

DENTAL LIMIACTIONS AND EXLUSIONS

- Demonstrated non-compliance with recommended course of treatment

- Services which in the option of the attending dentist, are neither necessary or recommended for the patient's dental health
- Restorations, splints and other appliances used to increase vertical dimension or restore occlusion
- Oral surgery requiring the setting of fractures or dislocation
- Treatment of malignancies, cysts or neoplasms or congenital melformations, except congenital anomaly of a tooth or teeth covered from birth
- Dispensing of drugs not normally supplied in a dental office
- Hospital benefits for any dental procedure
- Loss or theft of dentures or bridgework
- Any procedures of implantation or experimental procedures
- Services for injuries or conditions which are covered under Worker's Compensation or Employer's Liability laws. Services which are provided without cost to the member by any municipality, county or other political subdivision
- General anesthesia
- Services that cannot be performed because of the general health, physical or psychological limitations of the patient
- Periodontics, endodontics, oral surgery, orthodontics, prosthodontics, or pedodontics requiring the services of a non-participating dentist
- Those procedures requiring appliances or restorations that are necessary for full mouth rehabilitation, or to alter restore or maintain occlusion, including without limitation, treatment of disturbances of the temporomandibular joint
- Diagnosis and treatment of myofacial pain dysfunction syndrome
- Procedures performed in the hospital
- Plan members cannot have other dental coverage